

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2026
NAME OF PROVIDER OR SUPPLIER Carlisle Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Walnut Bottom Road Carlisle, PA 17013	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure dental services were provided to meet resident needs for three of three residents reviewed (Residents 1, 2, and 3). Findings include: Review of Resident 1's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and progressive multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves, which disrupts communication between the brain and the body). Review of Resident 1's clinical record progress notes revealed a Care Plan Meeting note dated October 2, 2025, at 8:38 AM, which indicated that Resident 1 and her Representative were present for the meeting and that Resident 1 wished to be seen by the dentist for possible dentures. Review of Resident 1's dental consultation dated November 18, 2025, and electronically signed by the dentist on November 23, 2025, revealed recommendations for Prevident 5000 Dry Mouth (sodium fluoride) gel 1.1% Use in place of regular toothpaste, brush teeth for 2 minutes then spit bid-AM and PM before bedtime. Refer to oral surgeon to extract all non-restorable teeth. The consultation failed to include any review signature by nursing staff or Resident 1's physician. Review of Resident 1's physician orders failed to reveal an order for an oral surgeon consultation or the Prevident gel. During a staff interview with the Nursing Home Administrator (NHA) on February 2, 2026, at 12:01 PM, the NHA confirmed that he had no additional information to provide for Resident 1. He further confirmed that the dentist's recommendations for an oral surgeon consultation and Prevident gel should have been completed when they were initially made in November 2025. Review of Resident 2's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and generalized muscle weakness. Review of Resident 2's clinical record revealed a dental consultation dated August 27, 2025, and electronically signed by the consultant dentist on January 19, 2026, which indicated Resident 1 had lost her upper and lower dentures and that the dentist had completed Step 1 for denture replacements. The note further indicated that Resident 1 was scheduled to be seen on November 14, 2025, for Step 2 of her denture replacement process. Review of facility provided information from their contracted dental services provider indicated that Resident 2 had been seen by the dentist on October 30, 2025, for Step 1 of her denture replacement process and that she was scheduled for November 14, 2025, for Step 2 of her denture replacement process. Further review of Resident 2's clinical record failed to reveal any additional dental consultations or dentist visit notes between August 27, 2025, and February 2, 2026. Review of Resident 2's clinical record progress notes revealed a Care Plan Meeting Note dated November 21, 2025, at 12:09 PM, which indicated that Resident 2's Representative had questioned the facility as to where Resident 2 was in the process of getting her dentures replaced. The note further indicated that Resident 2's Representative was informed that she was in Step 2 of her denture replacement process. Review of Resident 2's clinical record progress notes revealed a nurses note dated January 29,</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2026, at 5:01 PM, which indicated that Resident 2 's Representative inquired as to why Resident 2 still had not received her dentures yet. During a staff interview with the Director of Nursing (DON) on February 2, 2026, at 11:13 AM, she confirmed that Resident 2 had not been seen by the dentist since August 27, 2025. She provided a copy of an email dated February 2, 2026, at 11:26 AM, from their contracted dental services provider, which indicated that the dentist that covers the facility had been out on medical leave and they had no other providers in the area to cover the facility. The email further indicated that Resident 2 was scheduled to be seen on February 3, 2026. During a staff interview with the NHA and DON on February 2, 2026, at 12:24 PM, the DON indicated that she had been made aware that Resident 2's Representative had voiced a concern over the delay in getting Resident 2's dentures on January 29, 2026. The NHA indicated that their contracted dental services provider had not contacted the facility to inform them that their routine dentist was out on medical leave and that they had no other dental provider in the area. Review of Resident 3's clinical record revealed diagnoses that included neurocognitive disorder with Lewy bodies (a decline in mental functioning that happens when clumps of proteins called Lewy bodies build up in your brain cells, causing damage to the parts of the brain that affects thinking, behavior, movement and sleep) and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 3's clinical record revealed clinical record revealed a dental consultation dated August 27, 2025, and electronically signed by the consultant dentist on August 27, 2025, which indicated that Resident 3 had been seen for a periodic oral exam and was scheduled for a prophylaxis visit on December 27, 2025. Review of Resident 3's clinical record failed to reveal any dental consultations after his August 27, 2025, visit. During a staff interview with the NHA on February 2, 2026, at 12:01 PM, the NHA confirmed that he had no additional information to provide for Resident 3. He indicated that he had placed a call to the facility's contracted dental services provider to investigate what had happened with Resident 3's visit in December 2025. During a final staff interview with the NHA and DON on February 2, 2026, at 12:24, the NHA indicated that he had placed a call to the facility's contracted dental services provider to discuss the identified concerns as this was an ongoing issue with the provider. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		